Digitized by the Internet Archive
in 2009 with funding from
Ontario Council of University Libraries

http://www.archive.org/details/n05britishjournal23brit

RL
1
B7
v. 23
no. 5
c. 1
GERSTS

[o. 271.—Vol. XXIII. No. 5.] [MAY, 1911.

THE BRITISH JOURNAL OF DERMATOLOGY

CONTENTS.

PAGE

THE METABOLISM IN EXFOLIATIVE DERMATITIS. C. H. LETHEBY TIDY, M.A., M.B.Oxon., M.R.C.P.Lond. 133

ROYAL SOCIETY OF MEDICINE—DERMATOLOGICAL SECTION.—Cheilitis exfoliativa—Functional hysterical trophœdema—Herpes zoster—Erythema *ab igne*—Case for diagnosis—Acute Lupus erythematosus—Lichen scrofulosorum imitating psoriasis—Trichophyton roseum from a case of Tinea circinata of the arm—Trichophyton ectothrix from Tinea tonsurans—Trichophytic invasion—Angio-keratoma—Patch of three years' duration on cheek—Lupus . . 149

CURRENT LITERATURE—Granuloma pyogenicum—Cancer in tar workers—The nature of eyelid xanthoma—Syphilitic polyneuritis—Proliferating epidermic cysts—Study of a case of trichosporia—Is it possible to demonstrate the death of leprosy bacilli in the human organism?—On some points in the pathological anatomy of Lichen planus of Wilson—The elastic network of the wall of the sudoriparous glands—The Wassermann reaction in Alopecia areata—Alopecia areata, new researches on the causation of—Treatment of syphilis by the new Ehrlich-Hata preparation of arsenic ("606")—Pityriasis rubra pilaris as a family disease 161

REVIEW—Progressive Medicine 166

THE ELEVENTH VOYAGE D'ETUDES MÉDICALES 166

LONDON

H. K. LEWIS, 136, GOWER STREET, W.C.

LIBRARY
JUL 26 2002
UNIVERS
RONTO

PUBLISHED MONTHLY. PRICE TWO SHILLINGS.
ANNUAL SUBSCRIPTION POST FREE, ONE GUINEA.

BRITISH
JOURNAL OF DERMATOLOGY

J. H. SEQUEIRA, Editor.

J. L. BUNCH, Assistant Editor.

Under the direction of

H. G. Adamson	W. Allan Jamieson	George Pernet
Wallace Beatty	E. Graham Little	Leslie Roberts
T. Colcott Fox	J. M. H. MacLeod	J. H. Stowers
James Galloway	Sir Malcolm Morris	Arthur Whitfield

The Editor will be glad to receive for publication in the Journal original papers on subjects bearing on Dermatology, clinical records of unusual cases, observations on treatment, and notes on the histology and pathology of the skin.

All Correspondence respecting Contributions and other Editorial Communications should be addressed to the Editor, 8a, Manchester Square, W.

All Communications respecting Advertisements should be addressed to the Advertisement Manager, 8, Serle Street, Lincoln's Inn, W.C.

Exchanges, Books for Review, and all Business Correspondence to be addressed to the Publisher, H. K. Lewis, 136, Gower Street, W.C.

BRITISH JOURNAL OF DERMATOLOGY.

Annual Subscription, post free, One Guinea.

Subscriptions may be paid through a Bookseller or sent direct to the Publisher.

Binding Cases for 1910 (Vol. XXII) and for back Volumes can be supplied, price 1s. 6d. each.

H. K. LEWIS, 136, GOWER STREET, W.C.

WRIGHT'S COAL TAR SOAP.

"THE MEDICAL PRESS" says:—

"The actual tar bodies contained in it, prepared from

LIQUOR CARBONIS DETERGENS,

are of a complex character. On analysis we find the

TAR BODIES

amount to a little over 5%. Combined as they are they exert an

ANTISEPTIC ACTION

equal to a soap containing

15% PURE PHENOL,

but without its irritating effect. The knowledge of a

STANDARD SOAP

possessing

UNIFORM ANTISEPTIC VALUE

cannot be too widely spread."

DOES NOT STAIN SKIN OR LINEN.

SAMPLES FREE

TO MEDICAL MEN FROM THE PROPRIETORS,

WRIGHT, LAYMAN & UMNEY, LTD.,

SOUTHWARK, LONDON, S.E.

The "Allenburys"
Medical Soaps.

The "Allenburys" Medical Soaps are manufactured by a special process which admits of the addition of the special medicaments without in any way altering the composition of the soap-base or of the added ingredients. By this method absolutely accurate admixture and percentage composition is insured. None of these advantages can be obtained by the ordinary methods of manufacture usually in vogue.

The following list of Soaps is submitted, some of which have already been in use for a considerable time, and their utility widely recognised.

Carbolic 5% and 10%
Ichthyol 2½% with Resorcin 1¼%
Ichthyol 5% with Sulphur 5%
Ichthyol 5% with Salicylic Acid 2½%
Ichthyol 5% and 10%
Iodoform 5%
Resorcin 2½%
Resorcin 1¼% with Sulphur 5%
Salicylic Acid 5% with Sulphur 10%
Sulphur 5% with Peru Balsam 2½%
Terebene 10%
Thymol 2½%

A full list of Medical Soaps and a sample tablet of any variety sent on request.

Allen & Hanburys, Ltd., Plough Court, Lombard St., London, E.C.

Verlag von URBAN & SCHWARZENBERG, Berlin und Wien.

Soeben erschien:

Hautkrankheiten
sexuellen Ursprungs bei Frauen.

Von **Dr. Oskar Scheuer,**
Facharzt für Haut- und Geschlechtskrankheiten in Wien.

Preis geb. Mk. 10.—.

Diese Monographie über die Beziehungen der Haut zu den physiologischen und pathologischen Zuständen der weiblichen Sexualorgane ist für den Dermatologen wie Gynäkologen von gleich grobem Interesse.

MERGAL (Cholate of Mercury)

Invaluable in the treatment of syphilis. It allows the administration of mercury in large doses. Absorption can be easily controlled by exact dosage.
DOSE:—Two capsules three times a day after meals, gradually increasing dose.

PRICE TO THE PROFESSION—**2/6** per box of fifty capsules.

THE J. D. RIEDEL CO.
54 Cannon Street, London, E.C.

BERLIN :: NEW YORK :: MILAN :: ST. PETERSBURG

THE BRITISH
JOURNAL OF DERMATOLOGY.

MAY, 1911.

THE METABOLISM IN EXFOLIATIVE DERMATITIS.

By H. LETHEBY TIDY, M.A., M.B.,Oxon., M.R.C.P.Lond.,
Assistant Clinical Pathologist (late Medical Registrar), London Hospital; Physician to the Great Northern Hospital.

Introduction.

Many diseases of the skin have been attributed at one time or another to auto-intoxication, absorption from the intestines and similar disorders. A small proportion of such statements have been supported by analyses of the urine. Most of these are entirely valueless owing to ignorance, at the time, of the wide limits within which normal urine may vary on different diets, and to the omission of essential details.

Quincke (1), Stüve (2), Selenew (3), von Noorden (4), and more than all, Radaeli (5), have contributed reliable analyses.

Quincke showed that in diffuse diseases of the skin a large amount of water is lost through the skin by "insensible" perspiration.

Stüve found that the excretion of uric acid was increased in a case of Pemphigus vegetans.

Selenew collected the scales in a case of Pemphigus foliaceus and found they contained, on an average, 5 grm. of nitrogen daily. In this case the nitrogen in the food amounted to 28·00 grm. daily, and that in the urine to 14·69. Thus a very large retention of nitrogen apparently occurred. This has been observed in other cases of dermatitis. Selenew and others have suggested that this nitrogen

is lost from the surface of the skin and is not retained in the system.

Radaeli carried out a very careful series of analyses on pemphigus. He was able to show that the loss (or retention) of nitrogen became less as the skin condition improved. Unfortunately he did not measure the uric acid.

The analyses recorded in this article were carried out on three cases of exfoliative dermatitis in order to determine whether any ætiological factor could be discovered from a study of the urine. The three cases differed slightly from one another. The first two were primary, and of these the first was very obstinate, while the second recovered rapidly. In the third case the condition of the skin was undoubtedly secondary to the local use of a drug.

Similar analyses, for the purposes of control, were carried out on two normal persons and on a third who was gaining weight after rheumatic fever.

The analyses of the cases of dermatitis show an increased "loss" of fluid and nitrogen, presumably by the skin, and an increased excretion of uric acid. The conclusion is arrived at that these changes are secondary to the condition of the skin, and are not the cause of it.

For the inception of these analyses, the clinical notes, the cases examined, and much assistance in many ways, my thanks are due to Dr. Sequeira.

Diet and Technique.

The subjects on which the analyses were carried out were kept in identical conditions. The temperature and ventilation of the various wards was practically the same. All the patients were confined to bed with a regulation amount of clothing. The urine was collected daily from 6 a.m. one morning to 6 a.m. the following day. The diet was similar in the various cases. It consisted of milk, bread, meat, fish, bacon, eggs, potatoes, vegetables, and milk puddings. The character of the diet, and the amount were not strictly fixed, but varied slightly in character from day to day. The amount mainly depended on the appetite of the subject and no strict limitations were imposed. All fluid taken was carefully measured, and the solids weighed, each article being recorded with the hour at which it was

consumed. Care was taken to avoid the use of gravy, coffee and other substances which might specifically affect the excretion, but weak tea was allowed. The following may be given as the example of a day's *régime*:

6 a.m.—Breakfast: Weak tea, 5 oz.; milk, 2 oz.; bread, 6 oz.; bacon, 1 oz.; one egg.

8 a.m.—Milk, 8 oz.

12 a.m.—Dinner: Mutton, 6 oz.; potatoes, 2 oz.; cabbages, 2 oz.; bread, 2 oz.; milk pudding, 3 oz.; water, 5 oz.

3 p.m.—Tea: Weak tea, 12 oz.; milk, 2 oz.; bread, 9 oz.; butter.

7 p.m.—Milk pudding, 9 oz.; milk, 8 oz.

The nitrogen content of the diet was calculated partly from König's tables, and partly from estimations by Kjeldahl's method on samples. In calculating the amount of fluid allowance is made for the amount of water contained in the solid articles. Oxidation water is not included.

The urine was collected for periods of twenty-four hours, and the following estimations made daily:

(1) Total nitrogen, estimated by Kjeldahl's method.

(2) Urea, by decomposition with sodium hypobromite.

(3) Ammonia, by Schmidt's method.

(4) Uric acid, by Gowland Hopkins' method.

The specific gravity, reaction, presence or absence of albumen, sugar, and acetone, and the microscopical appearances of the sediment were examined daily.

Clinical Notes of Three Cases of General Exfoliative Dermatitis.

Case 1.—*Primary Relapsing Erythrodermia.*

Henry P—, an insurance agent, aged 29 years, admitted to the London Hospital, October 29th, 1908.

The case was one of general exfoliative dermatitis. The illness dated from February, 1908. There had been no previous cutaneous disease beyond a chronic scurfiness of the scalp. The onset of the present illness was acute, the eruption taking about a month to become universal. On admission, the case presented the usual

features—general redness, profuse exfoliation, loss of hair and nails. The temperature was raised for the first three weeks after admission, but the nocturnal elevations never exceeded 101° F. Weight, 8 st. 3 lb. The patient was wrapped up in the glycerol of lead lotion, and quinine was administered. By December 2nd he was somewhat improved, the temperature remained normal or slightly subnormal until the 16th, when a rise to 101·2° F. was recorded on December 20th. The pyrexia persisted until the middle of January. During this period the eruption became more acute, the redness increased, and the exfoliation again became profuse, and the hair again came off. During the next month there were two or three short febrile attacks, but the temperature never exceeded 100° F. The weight fell to 7 st. 2 lb. From February to April there was a steady improvement, the temperature remaining about normal, the skin cleared up to a remarkable degree, and cure appeared probable. The patient gradually put on weight, reaching 8 st. at the end of April. In May there was another relapse, the temperature rising to 102·6° F., and remaining raised for four weeks. With the pyrexia there was a recrudescence of the cutaneous symptoms. During the summer months of 1909 the temperature kept about normal, and the skin again improved, the weight rising to 8 st. 3 lb. During this period increasing doses of staphylococcal vaccine were given at ten days' intervals, by Dr. Western. At the end of September, 1909, there was again a relapse, with nocturnal temperature reaching 102·6° F., but this recrudescence was shorter than the previous ones, lasting only ten days. The vaccines were continued throughout this attack. With occasional rises, lasting a day or two, during October and November, the temperature remained normal till the patient's discharge to a Convalescent Home on January 8th, 1910. The skin gradually cleared up, the hair and beard began to grow, and when the patient was seen in April, 1910, he was quite well, and has remained so.

As may be imagined from the length of time the patient was in hospital many remedies were tried at different times, quinine, salicin, salines, arsenic, diuretics, etc., being given prolonged trials, but with the exception of some improvement under arsenic in the later months of 1909, nothing seemed to materially influence the condition. The staphylococcal vaccine was given after cultures had been made from

the blood. In one of these cocci were found, but it was doubtful whether they were not an accidental contamination. The blood examinations showed an excess of small lymphocyte cells—25·6 per cent. in an examination made in November, 1908. Later observations showed a proportion of small lymphocytes of 13·6 per cent. There was no leucocytosis.

Case 2.—*Recurrent Erythrodermia.*

The patient, William R—, a house-breaker, aged 48 years, was admitted to the London Hospital on January 8th, 1909. There was a strong rheumatic history in the family, but no member had had any skin-affection of a similar type. The patient admitted alcoholic excess, and attributed his present illness to this cause. He had good health except for the skin-eruption, which was first noticed at the age of fourteen. Since that time he had had at least twelve attacks resembling the one for which he was admitted, but in many instances the eruption was not universal. He gave a history of Pityriasis capitis of many years' duration, but a close questioning failed to elicit anything suggesting psoriasis or eczema.

The eruption began about the middle of December, 1908, on the arms and legs. It was accompanied by tingling, and in two or three days had spread all over the body. There was no malaise or sense of illness. On admission the skin was universally affected. The surface was bright red and covered with fine branny scales. There had been no weeping. The scalp was scaly but the hair had not fallen. The tongue was red and glazed, but there was no congestion of the fauces. The temperature was 98·8° F. There was no evidence of visceral disease.

The blood examination showed—red cells, 3,950,000; hæmoglobin, 80 per cent.; colour index, 1; leucocytes, 8600. The differential count showed—eosinophiles, 5 per cent.; polynuclear neutrophiles, 64·2 per cent.; large lymphocytes, 7·6 per cent.; large hyaline, 4·8 per cent.; small lymphocytes, 10 per cent.; basophiles, 0·6 per cent. Cultures were all sterile.

The patient was wrapped up in the glycerol of lead lotion and his bowels were kept loose with magnesium sulphate. The condition rapidly improved, and in a fortnight the redness had diminished and

the scaling was greatly lessened. The parts later were treated with glycerol of lead ointment. The eruption cleared up by the end of February, and the patient was discharged in the middle of March, 1909.

Case 3.—*Erythrodermia secondary to Psoriasis, and apparently caused by Treatment with Oil of Cade.*

The patient, Elizabeth S—, was a woman, aged 43 years. She gave a history of several attacks of "rheumatism," which appeared from the history to be of a subacute variety. There was no deformity of the joints suggesting rheumatoid arthritis. She had had many attacks of psoriasis dating from childhood, but had never had an outbreak like the one for which she was admitted to the London Hospital in June, 1909.

She had been given an ointment which was found to contain oil of cade, one drachm to the ounce. Particulars were supplied by the practitioner who had treated her. The whole of the trunk and the upper and lower limbs were red and scaling. On the fronts of the legs, in addition to the erythema and desquamation, there were numerous closely placed hemispherical papulo-pustules seated at the hair-follicles. No chrysarobin had been used, and the colour of the eruption did not suggest the application of this drug. The face was unaffected.

The urine was analysed between June 11th and 17th, 1909, for comparison with the two previous cases. It may be mentioned that the patient showed a marked intolerance to oil of cade, which was again used after the eruption had cleared up with a view to determining whether it could have been the cause of the outbreak. The condition of the legs was exactly the same as when the patient was admitted, and the redness and scaling spread up onto the thighs and threatened to become generalised.

The Condition of the Urine in the above Cases.

Case 1.—Henry P—, aged 29 years. During the long period over which this patient was in hospital four series of analyses were carried out. These were as follows:

Period 1: January 23rd to February 12th.—The skin condition was very severe at the commencement, but during the period showed signs of improvement. The general condition was poor. There was occasionally slight pyrexia. The bowels were regular and the number of motions normal. The weight was practically stationary.

Period 2: April 2nd to 8th.—The skin condition had improved considerably by this time in comparison with the preceding period, but there was still a severe general dermatitis. The general condition was good, and a rapid gain in weight had occurred immediately before the period commenced. There was no pyrexia. The bowels were normal and the weight stationary. No noticeable change occurred during the period.

Period 3: July 15th to 21st.—After the relapse in May an improvement had again set in, though slowly, and the dermatitis at this time was less marked. During the period little change was noticeable. The general condition was good. There was no pyrexia. The bowels were normal and the weight stationary.

Period 4: November 25th to 30th.—The final improvement in the skin condition lasted from the middle of November until the discharge in January. The general condition was improving rapidly after a previous loss in weight.

During the periods of analysis drugs were avoided, except mild aperients and vaccine injections. The appetite was good throughout.

The analyses during the different periods will be referred to separately.

Period 1: *General characters of the urine.*—The reaction was either alkaline or neutral. On one day it was slightly acid. The specific gravity varied between 1017 and 1025. No albumen was detected on any day by Heller's test, or by acidifying and boiling. The deposit contained phosphate, oxalate and uric acid crystals, and occasionally a few epithelial cells. No casts were found.

Amount of urine.—The amount of urine passed showed considerable daily variations, but if the period be considered week by week it is found that the amount increased towards the end of the period. The "loss of fluid" (that is, the amount ingested less the amount of urine) shows this change distinctly, diminishing from 1250 c.c. to 660 c.c. The loss is very large at the commencement.

Total nitrogen.—The total nitrogen excreted was remarkably low

throughout. It fell to a minimum in the middle of the period, the daily analysis showing this better than the weekly means. For a few days it reached the extraordinarily low figure of 3 grm. The "loss of nitrogen" (that is, the amount ingested less the amount in the urine) is very high throughout, especially as the amount of nitrogen ingested was not very large.

Urea.—The amount of urea passed and the percentage of urea-nitrogen follow the rules enumerated by Folin, that is to say, the percentage and the amount fell together. On January 28th the amount of urea fell to 1·66 grm. Apart from gross urinary conditions, this appears to be the lowest amount of urea that has been recorded. The amount of urea, as in the case of nitrogen, reached a minimum in the middle of the period.

Ammonia.—The amount of ammonia and percentage of ammonia-nitrogen fluctuated considerably from day to day. Both rose towards the end of the period.

Uric acid.—Both the total amount and the percentage of uric acid nitrogen were extremely high throughout. The percentage rose to 9·5 on January 27th, and the total to 0·52 grm. on February 4th. It is probable that the amount was falling towards the end of the period.

Undetermined nitrogen.—This is calculated by difference, and includes kreatinine, which was not separately estimated. The amount varies greatly from day to day, but the means calculated weekly vary less. The results are within the limits of normal according to Folin's analysis. The percentage is very high.

Period 2: *General characters.*—The reaction was neutral or slightly alkaline. A trace of albumen was present every day. No casts were found on any occasion. The deposit contained phosphates and urates.

Amount of urine.—The amount was small, the loss of fluid being very high.

Total nitrogen.—The amount of nitrogen excreted was again very low, although it did not reach the minimum of the preceding period. The loss of nitrogen was very high.

Nitrogenous constituents.—The amount of urea and percentage of urea-nitrogen are in accordance with the total nitrogen.

Compared with Period 1, there is a marked reduction in the amount of uric acid and ammonia. The uric acid is apparently about normal for the diet. The ammonia is distinctly low in amount. The

total amount of "undetermined nitrogen" closely agrees with the preceding period.

Period 3.—The diet was not recorded during this period. In character it was similar to that in the previous series.

General characteristics.—The reaction was neutral or alkaline. A very faint trace of albumen was present daily. No casts were found. The deposits contained phosphates and urates, and occasionally uric acid crystals.

Amount of urine.—The amount was somewhat low.

Total nitrogen and nitrogenous constituents.—The amount of nitrogen excreted showed a distinct increase. In accordance with this the partition of nitrogen approaches normal limits. The amount of nitrogen is still low, even for a man of so small a build and light a weight as the patient. The uric acid excretion is high. It is equal to the largest amount excreted by any one of the University College Physiologists, although that individual weighed 94 kilos. and excreted 16 grm. nitrogen.

Period 4.—This period differs from the others owing to the rapid gain of weight. By an oversight the administration of a mixture containing acid sodium phosphate was continued. This accounts for the large excretion of ammonia, presumably at the expense of urea.

General characteristics.—The reaction was slightly acid. A very faint trace of albumen was present. No casts were found.

Amount of urine.—The amount was low. The "loss of fluid" was not very high.

Total nitrogen and nitrogenous constituents.—The amount of nitrogen is very low, especially when the large diet is considered. The percentage of nitrogen excreted as urea and ammonia is within normal limits. The amount of uric acid is high.

Consideration of the analyses.—The final period differs from the preceding in the rapid gain of weight, and will be referred to separately.

Considering the first three periods together, noticeable features are:

(1) *Loss of fluid.*—The loss of fluid is very large, and becomes even more marked when the light weight of the patient is considered. In the period January 23rd to February 12th the mean of eighteen analyses gives a loss of 6 c.c. per hour per 10 kilos. The control case,

No. 1 (*vide* Table), estimated during November, gives a loss of 4 c.c. per hour per 10 kilos. The analyses of Quincke, calculated by the same method, and of Schwenkenbecker, estimated hygrometrically, gave the same result. In the first period the loss is greatest during the earlier days. This might seem to agree with the severity of the dermatitis, but the loss during April is even greater, although the condition of the skin was certainly not so bad.

It is justifiable to conclude that the loss of fluid from the surface of the body is excessive.

(2) *Excretion of nitrogen.*—The total nitrogen of the urine is extraordinarily low throughout the first two periods. The minimum is found at the end of January and beginning of February, the nitrogen falling on January 28th to 2·88 grm. This is far lower than the figures which are found in cases of complete starvation. It is about equal to the lowest figures found on Folin's "starch and cream" diet. Cathcart found similar figures when he placed a professional faster on the "starch and cream" diet after a fortnight's complete fast. It has been suggested that this analysis represents closely the endogenous metabolism of nitrogen, on the grounds that the starch and cream diet has sufficient caloric power to supply the energy of the body from material which is efficient though non-nitrogenous. Hence it would appear that in this case the total nitrogen of the urine similarly represents mainly endogenous metabolism, whilst most of the nitrogen resulting from the exogenous metabolism is excreted through other channels.

Although the nitrogen of the fæces was not estimated, yet as the number of motions was normal, it is improbable that more than 2 grm. a day would be thus excreted. The skin remains as the only means by which this nitrogen could have passed from the body. The daily loss of nitrogen during the first period is on the average 8·18 grm., and during the second period is 7·81 grm. During the third period the diet unfortunately was not measured, but the excretion of nitrogen was higher than in the preceding periods.

We may conclude that during these periods the loss of nitrogen through the skin was very large, and included a large proportion of the nitrogen resulting from exogenous metabolism.

The partition of nitrogen among the various constituents estimated becomes of particular interest in view of the reduction in the total

excretion. It will be seen that with the exception of uric acid, the distribution of nitrogen agrees with that found in the other instances just mentioned of low nitrogenous excretion. This is especially seen in the low percentage of nitrogen contributed by urea. This partition of the nitrogen affords a further support of the suggestion that the excretion at this point mainly represents the endogenous metabolism.

(3) *Excretion of uric acid.*—Throughout the first period the excretion of uric acid was extremely high, even in comparison with men on full protein and purin-containing diets. In the second period the excretion was normal for such a diet, and in the third it is again high. It is in the first period that the excretion is furthest removed from normal. Apart from the administration of excessive quantities of purins, no diet results in an excretion of uric acid approaching these amounts. Hence it cannot be argued that the amount is due to both the endogenous and exogenous uric acid being excreted in the urine. It must be accepted that the amount of uric acid is connected with the disease.

(4) *The condition of the kidneys.*—No albumen was present in the urine during the first period. Throughout the succeeding periods, including the last, a trace of albumen was present daily. It was often very faint. The amount showed no tendency to increase. No casts were found. Hence it would appear that the presence of albumen was a secondary occurrence. There is no evidence that any disease of the kidney was present.

In Period 4 a rapid gain of weight occurred. Therefore the analyses are not comparable with those of the preceding periods. If comparison is made with the control case, No. 1 (*vide* Table), it will be seen that the retention of nitrogen and the percentage excreted as urea agree closely in the two cases. The excretion of uric acid is more than double in the case of dermatitis.

Case 2.—William R—, aged 48 years. The analyses covered a period of three weeks. During this time the dermatitis rapidly improved and the skin was practically normal by the commencement of the third week. The weight remained stationary throughout. The mean of the analyses for each week has been calculated.

General characters of the urine.—The reaction was acid throughout. The specific gravity varied between 1016 and 1022. A trace of albumen was present on three days towards the end of the first week.

The deposit usually contained epithelial cells and urates. No casts were found.

Amount of urine.—The amount of urine passed was never below normal. It increased somewhat in the final week. The "loss of fluid" (that is, the amount ingested less the amount of urine) is distinctly less in the final week than previously.

Total nitrogen.—The total nitrogen excreted was distinctly low, but increased week by week. During the final week it reached normal limits. The loss of nitrogen fell during the period, being distinctly high at the commencement.

Nitrogenous constituents of the urine.—The excretion of urea increased both absolutely and relatively with the increase in the total nitrogen. The ammonia and the undetermined nitrogen fall within normal limits. The excretion of uric acid is distinctly high during the first week, but is normal in the last two weeks.

Consideration of the analyses.—This case differs from Case 1 as the skin condition was rapidly improving during the period of analysis, and was practically normal during the third week. Therefore it is important to notice what differences are revealed between the earlier and the later periods.

(1) *Loss of fluid.*—The loss of fluid is never excessive, but is somewhat less in the final period. The difference is not so large that any definite conclusion can be drawn from it.

(2) *Excretion of nitrogen.*—The excretion of nitrogen never falls to the low figures observed in Case 1, but it appears to be distinctly subnormal at the commencement, and shows a definite increase in the final week. The "loss of nitrogen" is high in the first two weeks, and falls to normal limits in the third week. A definite relation is thus seen between the condition of the skin and the amount of nitrogen excreted in the urine.

The partition of nitrogen among the various constituents agrees with what would be expected with the exception of uric acid. During the first week the uric acid is markedly high, whether we compare it with the figures accepted as normal on ordinary diets, with those found in our own control analyses, or with those for the final two weeks of this same case. Thus these analyses, as those of Case 1, suggest a connection between the excretion of uric acid and the presence of the dermatitis.

(3) *Condition of the kidneys.*—A trace of albumen was present on three days only. No casts were found. There is no reason to suppose that any organic disease of the kidney was present.

Case 3.—Elizabeth S—, aged 43 years. The analysis covered a period of six days. The diet was not measured.

General characters of the urine.—The reaction was acid throughout. The specific gravity varied from 1027 to 1032. A trace of albumen was present on the last two days of the analyses. No casts were found.

Amount of urine.—The amount of urine passed was low.

The excretion of nitrogen.—The total nitrogen excreted was within normal limits. With the exception of uric acid the partition of nitrogen was also normal. The excretion of uric acid is distinctly high.

Consideration of the analyses.—Although the skin condition closely resembled that of the two previous patients, yet the case differs in the fact that an undoubted cause can be recognised for the dermatitis. The analyses are normal with the exception of the amount of uric acid. We can draw the following conclusion—that in this case, as in the others, the amount of uric acid excreted must be supposed to have some connection with the condition of the skin.

The Condition of the Urine in Three Persons not Suffering from Dermatitis.

Analyses of the urine were carried out as a control in three cases. Two of these (Nos. 1 and 2) were in hospital for small surgical operations, and there is no reason to suppose that the metabolism was otherwise than normal. The remaining case (No. 3) was convalescent from a severe attack of acute rheumatic fever, and was rapidly gaining weight. The diet, technique and general conditions were exactly similar to those of the cases of dermatitis. The first two cases show a close agreement with the mean of Folin's analyses of normal urine: for example, the loss of nitrogen (the difference between the nitrogen ingested and that excreted in the urine) and the partition of nitrogen (*vide* Table). The amount of uric acid excreted in No. 1 is higher than the mean of Folin's analyses, but the diet was not purin free. The amount agrees closely with that found by the

observers at University College and others elsewhere. It is markedly below the figures found in the cases of dermatitis.

In the third case there is a large retention of nitrogen, the amount excreted being very small. The percentage of urea nitrogen shows a considerable fall, whilst the percentage of undetermined nitrogen is high. Indeed, the figures agree with what one would expect in view of the low amount of nitrogen in the urine. The amount of uric acid excreted is exactly equal to what Folin considers to be the result of endogenous protein metabolism in a man of the same weight.

These three cases show that the method of analysis adopted gives normal results when applied to normal persons. Therefore we are justified in drawing conclusions from the analysis found in the patients suffering from dermatitis.

General Conclusions from the Analyses.

General Conclusions on the Condition of the Urine.

From Cases 1 and 2 the following conclusions may be drawn, taking into consideration the results found in the control analyses and those of previous observers:

(1) Albumen is not necessarily present, and more than a trace was never found. There was no tendency for the amount to increase. No casts were seen. Thus there is no evidence of the presence of nephritis.

(2) The excretion of nitrogen and fluid in the urine is deficient. The amount of "retention" and the severity of the affection vary together. The excess of nitrogen and fluid is excreted by the skin.

(3) The excretion of uric acid is excessive. The amount excreted diminishes as the condition of the skin improves.

(4) The excretion of urea and undetermined nitrogen is not abnormal in relation to the amount of total nitrogen.

In Case 3 the excretion of uric acid agrees with what has been said above, but apart from this the analyses are approximately normal.

The Relation of the Dermatitis to Changes in the Urine.

On the conclusions given above the following questions may be considered:

	Date.	Weight (kilos).	Change of weight during period.	Intake of fluid, c.c.	Volume of urine, c.c.	Loss of fluid, c.c.	Percentage of intake.	Nitrogen in food, grammes.	Total nitrogen in urine, grammes.	Loss of nitrogen, grammes.	Excretion of nitrogen in urine, grammes.				Partition of nitrogen in urine (per cent.).			
											Urea N.	Ammonia N.	Uric acid N.	Undetermined N.	Urea.	Ammonia.	Uric acid.	Undetermined
Case 1. — Henry P—	Jan. 23–28	46·15	−0·04	2270	1020	1250	55·1	12·79	6·11	6·68	4·09	0·23	0·40	0·39	66·9	3·8	6·5	23·8
	Feb. 1–6	46·11	−0·03	1990	990	1000	50·3	13·75	5·09	8·66	3·68	0·24	0·34	1·83	72·3	4·7	6·7	16·3
	Feb. 7–12	46·08	−0·31	2090	1430	660	31·6	15·98	6·64	9·32	4·91	0·40	0·32	1·01	74·1	6·0	4·8	15·1
	Mean: Jan. 23–Feb. 12	—	—	2110	1120	990	46·9	14·02	5·84	8·18	4·14	0·28	0·36	1·08	70·9	4·8	6·2	18·1
	April 2–8	50·43	+0·11	2250	720	1530	68·0	13·42	5·61	7·81	4·06	0·17	0·19	1·19	72·4	3·0	3·4	21·2
	July 15–21	50·00	+0·06	—	920	—	—	—	8·59	—	7·08	0·22	0·25	1·04	82·4	2·6	2·9	12·1
	Nov. 25–30	49·30	+1·75	1590	720	870	54·7	16·98	6·96	10·02	5·34	0·65	0·27	0·70	76·7	9·3	3·9	10·1
Case 2.—William R—	Feb 1–7	64·46	+0·20	1960	1370	590	30·1	13·64	8·54	5·10	6·43	0·28	0·31	1·52	75·3	3·3	3·6	17·8
	Feb. 8–14	64·66	−0·23	2000	1220	780	39·0	14·38	9·13	5·25	6·93	0·37	0·21	1·58	75·9	4·1	2·3	17·4
	Feb. 15–21	64·43	+0·31	1890	1450	440	23·3	14·46	10·61	3·85	8·70	0·31	0·21	1·39	82·0	2·9	2·0	13·1
	Mean: Feb. 1–21	—	—	1950	1350	600	30·7	14·16	9·43	4·73	7·37	0·32	0·24	1·50	77·8	3·4	2·6	16·2
Case 3.—Elizabeth S—	June 11–17	62·53	−0·88	—	860	—	—	—	13·28	—	11·51	0·31	0·33	1·13	86·7	2·3	2·5	8·5
No. 1 (control) .	Nov. 28–Dec. 2	69·61	−0·24	2200	1500	700	31·8	17·04	14·38	2·66	12·66	0·67	0·21	0·84	88·0	4·7	1·4	5·9
No. 2 (control) .	March 17–23	52·84	+0·11	—	1190	—	—	—	12·28	—	10·82	0·23	0·14	1·09	88·1	1·9	1·1	8·9
No. 3 (control) .	Nov. 11–16	63·21	+1·40	2050	1230	820	40·0	15·26	6·69	8·57	5·15	0·33	0·12	1·09	76·9	4·9	1·8	16·4
Previous observations:																		
Folin (Normal)		63·0	—	—	—	—	—	18·90	16·00	2·90	13·9	0·70	0·12	1·18	87·5	4·3	0·8	7·35
University College Physiologists (Normal)		—	—	—	—	—	—	—	13·50	—	—	—	0·21	—	—	—	1·5	—
Quincke (Normal) . . .		59·8	—	2271	1668	603	26·2	—	—	—	—	—	—	—	—	—	—	—
Quincke (Eczema) . . .		55·0	—	1948	972	976	50·1	—	—	—	—	—	—	—	—	—	—	—
Stüve (Pemphigus vegetans) .		70·0	−3·00	2000	1005	945	47·3	20·08	17·34	2·74	—	—	0·37	—	—	—	2·4	—
Selenew (Pemphigus foliaceus).		—	—	—	—	—	—	28·00	14·69	13·64	—	—	—	—	—	—	—	—
Radaeli (Lichen planus) . .		—	—	—	—	—	—	19·55	17·69	—	15·36	—	0·23	—	86·8	—	1·30	—
Radaeli (Pemphigus) Case 13, three periods . . .		—	—	—	—	—	—	13·54	9·13	4·41	—	—	—	—	—	—	—	—
		—	—	—	—	—	—	13·51	11·10	2·41	—	—	—	—	—	—	—	—
		—	—	—	—	—	—	13·52	12·39	1·13	—	—	—	—	—	—	—	—

(1) Is the condition of the skin secondary to changes in the kidneys?

Since there is no evidence in the urine of the presence of nephritis, there is no reason to suppose that the dermatitis is primarily due to a pathological condition of the kidneys. Hence the abnormal condition of the urine must be considered to be secondary to the changes in the skin.

(2) Is the condition of the skin connected with the excretion of uric acid?

It has been seen that the amount of uric acid excreted is increased not only in Cases 1 and 2, in which the dermatitis is "primary," but also in Case 3, in which it was undoubtedly secondary. Hence it is impossible to avoid the conclusion that there is a direct connection between dermatitis and the amount of uric acid excreted.

It may be justly argued that the balance of nitrogen is excreted by the scales of the skin, and no significance need be ascribed to the low amount of urea and the partition of urinary nitrogen.

Now it is held at the present time that the uric acid of the urine has two sources—exogenous and endogenous. The exogenous uric acid is the direct product of the purins taken in the diet. Probably the tissues withdraw from the ingested purins the quantity which they require, and the remainder, or some portion of it, is excreted unchanged as uric acid. This moiety can be eliminated by administering a purin-free diet. The endogenous uric acid is the result of the disintegration of nuclear tissue. The leucocytes are normally the most important source of this moiety, but all nuclear tissue contributes, and an increased activity of any tissue will produce an increase of uric acid.

In the cases of exfoliative dermatitis there is undoubtedly an increased activity of the skin and an increased excretion of uric acid. From the surface of the body pass large quantities of scales containing nitrogen, but no nuclein. Thus the uric acid produced by the nuclear activity must pass inwards, and finally reach the kidneys.

Such a view explains the diminution of the urinary nitrogen and the increase of uric acid.

A similar diminution of the total nitrogen and increase of the uric acid is seen in the analyses of a case of pemphigus recorded

by Stueve. The prolonged exposure of men to a temperature of 26–30° C. by Linser and Schmidt resulted in a similar change.

Apparently we are compelled to arrive at the conclusion that the changes observed in the urine are secondary to, and a necessary consequence of, the activity of the skin. No conclusions as to the origin of the dermatitis can be derived from the consideration of the urine, but the presence of the changes observed suggests that measures should be taken for preserving the kidneys from further unnecessary strain whilst the condition is present.

References.

(1) Quincke.—*Derm. Zeitschr.*, i, 1894.
(2) Stüve.—*Arch. f. Derm. u. Syph.*, 1896, xxxvi. p. 191.
(3) Selenew.—*Derm. Zeitschr.*, xii. 1905, p. 569.
(4) Van Noorden.—*The Pathology of Metabolism*, p. 754.
(5) Radaeli.—*Giorn. Ital. d. Mal. Ven. e della Pelle.*, 1901 and 1903.

ROYAL SOCIETY OF MEDICINE.

DERMATOLOGICAL SECTION.

Meeting held on Thursday, April 20th, 1911, Dr. Colcott Fox, President of the Section, in the Chair.

Dr. Haldin Davis (for Dr. Adamson) showed a case of *Cheilitis exfoliativa*. The patient was a young woman, aged 18 years, unmarried, who followed the occupation of a waitress. Four years ago vertical cracks had appeared near the centre of the lower lip on each side of the middle line. These cracks bled very much, but, except that the lips became dry, they remained otherwise normal. After a time, however, the lips began to crust over, but up till six months ago the upper lip remained unaffected. The lower lip was now entirely covered with a thick black scale or crust, here and there consisting of dried blood. The upper lip was more slightly fissured, and showed brownish scales, but not crusts, which had been exfoliated. The crust could be removed entirely. Underneath the skin was dry and shrivelled, and soon cracked, bled, and formed another crust. According to the patient, if left alone the crust became loose in the

course of about five days, and could then easily be detached, but another one soon formed. The only other points worthy of mention concerning her skin were, that she had considerable seborrhœa of the scalp, and also some seborrhœic patches on the face. She exhibited two Bean's lines on the nails.

She was anæmic in appearance, and had attended for some considerable time at the Gynæcological Department at St. Bartholomew's Hospital for uterine hæmorrhage, but at the time of the examination had had amenorrhœa for several months. It was suggested by the exhibitor that the most promising method of treatment would be by means of X-rays.

Sir MALCOLM MORRIS said he had seen one case associated with black tongue. He thought a much better result would be produced by radium than by X-rays.

Dr. GRAHAM LITTLE recalled a very similar case he had brought to the Section (*Brit. Journ. Derm.*, 1909, p. 252). This had also occurred in a young woman. It seemed to benefit, at least temporarily, with zinc ionisation.

Dr. MACLEOD said he had under his care at present a more marked case of the same condition, which he had found most resistant to treatment, the X-rays being of practically no benefit. He pointed out that there was another affection which was somewhat similar, in which there was a scaly, thick, exfoliative condition of the lips, possibly seborrhoic, which reacted well to the X-rays.

Dr. FEARNSIDES (introduced) showed (by permission of Dr. HENRY HEAD) a case of *functional hysterical trophœdema*. H. B—, a grocer's boy, aged 16 years, had been in constant employment with the same firm for two and a half years, when one Tuesday afternoon in November last, 1910, whilst at work, knocking nails with a hammer out of a butter-tub lid, the wood slipped, and a wire nail entered the dorsal aspect of the first interosseous space of his right hand. The nail entered the flesh deeply and caused a considerable amount of pain at the time, which, however, soon ceased. The wound bled freely. His right hand was immediately bound up, and he continued his work till evening.

At 8.30 p.m. on the same evening just before leaving for home he went to pick up a knife and found that his right hand "had suddenly gone weak" and that he had "no use at all in the hand."

The next day he went to work in the morning and was sent out as usual to get orders. This should have entailed his writing the names of the customers down in a book, but on this morning his hand was

so weak that he could not write, and he had to ask each customer to write down the orders in the book.

On his round B— suddenly decided that his hand being so weak he must seek medical advice and went to East Ham Hospital, where he saw the doctor in attendance, who ordered fomentations to the thumb. On this date he stated that his right thumb swelled up generally "just like his whole hand did at a later date." The wound was treated with fomentations for three days and appeared to heal by first intention, so that he was discharged without a bandage on the Friday. On this day (three days after the accident) five or ten minutes after leaving the hospital he noticed that his right thumb and hand were "all swollen again," and by the same evening "very much swollen and black in colour." The swelling came up in the day-time and went down somewhat at night. The swelling gradually increased in amount, so that on the seventh day following the accident he returned to East Ham Hospital for further advice and treatment. On this day the swelling was very marked and reached all over the hand as far as the wrist. The whole hand was painted with iodine and wrapped in lint, a line of treatment which was repeated at the next visit four days later. He again attended at the hospital on the following Monday (thirteen days after the accident), when expectant treatment was adopted. This line of treatment did not satisfy his parents, who accordingly on the next day took him to West Ham Hospital, where he was considered at first to be suffering from a septic thumb and again treated with fomentations. This seems to have increased the amount of swelling, and so, after a seven days' trial, lead acetate lotion was tried, and persisted with for fourteen days without any good effects. He was told then to go about with his hand free and use it as much as possible. The swelling never disappeared, although it varied in amount from time to time, going down at night and increasing towards the end of the day.

Five weeks after the accident active treatment was again adopted, cold compresses being again employed and persisted in for another fourteen days.

Nine weeks after the accident he appeared at the Out-patient Department of the London Hospital, where he was seen by Mr. Sherren and subsequently by Dr. Head, and his case was taken to be one of functional (hysterical) trophœdema.

From February 2nd to the 28th he was an in-patient under Dr. Head, under whose care he still remains, and whom Dr. Fearnsides has to thank for permission to show the case.

At this time he showed recurrent, soft, pitting œdema of the whole of his right hand, on the dorsal surface to a greater extent than on the palmar, coming on chiefly towards evening, with glossy, congested skin over, and local sweating. The line of demarcation of affected and unaffected skin was not a very sharp one, but lay exactly at the level of the carpo-metacarpal joint. The colour of the hand varied from pink when covered to a bluish tint after exposure. The muscles of the right hand were somewhat wasted as compared with the corresponding ones of the left. All movements of these muscles could be voluntarily carried out, but apparently only with difficulty and only feeble in degree, being limited by the swelling. The loss of voluntary power affected flexion and extension equally. The ulnar and median supplies over the hand were equally affected. There has been no pain. The nails were practically unaffected. There has been no sensory loss as tested by pin-prick, cotton-wool, heat, cold, and passive movements. The reflexes everywhere were present and unaltered. The fundi and fields of vision for white and colours were quite normal. There has been no enlargement of the glands anywhere, and no signs of other lymphatic obstruction. It was noticed that in walking he fixed his right shoulder and tilted his spine, so that his right arm swung pendulum-wise from his side. Active and passive movements at the right shoulder were perfect. There was typical anæsthesia of the palate. Heart, lungs, and other systems were normal.

The case was considered to be one of hysterical (psychical) vaso-motor and lymphatic disturbance. He was treated with massage (ten minutes daily) exercises and passive movements.

Whilst he was an in-patient the pitting œdema became much less marked, but his nails became somewhat uneven and the red and glossy skin and local sweating remained as marked as ever.

Since his discharge on February 28th last he has been attending our massage department three times a week and Dr. Fearnsides has seen him from time to time. He has been going about at home. The œdema has tended to increase, but has varied somewhat in amount from day to day. Suspecting that possibly active measures

on the part of the patient might be keeping up the condition, on the 12th inst. the hand and forearm, excluding the fingers, were encased in plaster-of-Paris, and since that time the swelling has decreased to a very marked extent. The plaster was removed to-day (the 19th), and the hand re-photographed.

His previous history presented no remarkable features; he was in general a well-informed boy, well up to the average intelligence of boys at his age in his station of life. As a child he had measles and whooping-cough. Since leaving school he had only been away from work three days, when he attended a doctor in August, 1910, because he was a little "run down" after an alveolar abscess.

He was the eldest of seven children, and as far as Dr. Fearnsides had been able to ascertain there was no psychopathic family history.

Since the accident in November last he has been continuously in receipt of 9*s.* 3*d.* a week—his earnings before this were 10*s.* weekly. The case appeared to be one of local lymphatic paralysis of mental origin, and gave an opportunity for testing the soundness of the divergent views on hysteria held by the two French schools headed by Janet and Babinski. An attempt is being made to prevent fraud on the part of the patient by means of a plaster-of-Paris encasement, and so far the evidence would suggest that the case might be held to support Babinski.

Dr. Parkes Weber remarked that there was quite an extensive foreign literature on the subject of chronic œdema of the hands (chiefly the backs of the hands) following traumatism.*

Dr. Graham Little showed (1) a case of *Herpes zoster* in a man, aged 50 years. The eruption had appeared for the first time five days previously "after having his hair cut," and involved the whole of the left side of the forehead and scalp, the vesicles being typical in appearance, many of them hæmorrhagic and in some cases running into bullæ. The upper and lower left eyelids were enormously swollen, especially the lower lid, so that the eyeball was completely occluded; a point of much interest and rarity was that the *right* lower eyelid was also much swollen, but not nearly so greatly as the left; the skin covering the nose at the level of the bridge was slightly

* See the writings of Secrétan (1901), Borchard, R. Grünbaum, Patry, Van Trooijen (1910), etc. Dr. Weber believes that a similar chronic œdema sometimes occurs in the foot after traumatism.

puffy. There was no free suppuration and the swellings were entirely œdematous. There had been no pain previous to the appearance of the eruption, which was also an exceptional experience, as in this position Herpes zoster was usually especially painful.

The eruption corresponded absolutely with the figures shown by Head ("Pathology of Herpes Zoster," *Brain*, part iii, 1900, p. 509, fig. 19; "Disturbances of Sensation and the Pain of Visceral Disease," *Brain*, part iii, 1894, p. 375) for the distribution of the superior ophthalmic division of the fifth nerve. Head notes in the second case referred to that the lower eyelid on the same side as the eruption was much swollen; the swelling of the lower eyelids of both sides seemed not to have been recorded before.

Sir Malcolm Morris considered that when, in such cases, the nasal branch was involved the outlook for the eye was bad. Recently a lady patient of his came out of the theatre, and as her carriage did not draw up for some time she stood on the pavement waiting for it in a cold east wind. Three days after that exposure she came out in a similar condition to this patient. She did not become septic, but there was a danger of that happening. The lids of both eyes began to be affected at the same time. In this case the pain was intense and lasted for many weeks. Mr. Jessop saw the lady for her eyes.

Dr. Sequeira looked upon the œdema of the lower lid on the opposite side to the herpes as a simple extension due to anastomoses of the lymphatics across the bridge of the nose.

(2) A case of *erythema ab igne*. The patient was an anæmic and delicate-looking boy, aged 13 years, the subject of congenital hernia, for which he was awaiting operation. The history given by the mother and the boy was that he had for the past three weeks been feeling poorly and easily chilled, and had spent several hours daily sitting close up to the fire; the changes in pigmentation had not been noted before this period, namely, three weeks. There was now a well-marked fenestrated pigmentation on the front of both legs just below the knee; of exceptional interest was the fact that the pigmented mesh-like lesions were also raised and almost warty. Perry had recorded a similar condition in erythema *ab igne* (*Brit. Journ. Derm.*, 1900, p. 94). In addition to the pigmentation on the legs there was a similar mesh-like pigmentation of the back of both hands, but especially of the right hand; here the pigmented areas were completely flat. The boy gave the explanation that he habitually had his hands spread out over his knees when sitting by the fire. The occurrence

of the eruption on any other part except the legs was very unusual. Crocker records that the pigmentation had been noted on the hands and arms in one case he had seen (*Text-Book*, third edition, under heading "*Erythema ab igne*"). The time within which the condition had developed seemed incredibly short, but the history was persisted in by both the patient and his mother. The boy had a slightly xerodermic skin, not amounting to ichthyosis; the skin on the front of the knees was thickened, and it was suggested that the elevation of the lesions might be explained by this circumstance.

Sir MALCOLM MORRIS said that in the cases of the kind he had seen the condition arose only after very prolonged warming at the fire. He did not think it likely that only three weeks' warming would suffice to bring out the present condition. Children at institutions sometimes were found with a similar condition on account of stasis and cold.

Dr. WHITFIELD said he believed that the epidermic thickening was akin to angio-keratoma in the way of production. He thought there was first chronic congestion with telangiectasis, and upon this a certain degree of wartiness developed.

Dr. PARKES WEBER remarked that if Dr. Little's explanation of the reticular markings on the legs and backs of the hands was (as seemed probable) the correct one, the peculiar condition of the skin (which was rough and slightly raised above the general surface) of the pigmented lines on the legs might be accounted for as a result of heat and venous engorgement in a boy whose natural tendency to hyperkeratosis was proved by the rough, thickened skin in front of both his knees.

Dr. J. M. H. MACLEOD showed a *case for diagnosis*. The patient was a woman, aged 50 years, who, though of a somewhat delicate appearance, had enjoyed good health, and lived most of her life in the country. When a child she had tuberculous glands of the neck, the scars from which were still evident, but she had no other physical signs of tuberculosis. There was a definite tuberculous family history, however, a sister of the patient having died of phthisis. The condition for which the patient was exhibited was a peculiar affection of the face characterised by the presence of subcutaneous thickenings, which were flat, well-defined, and felt like pieces of indiarubber, with rounded edges situated in the hypoderm. The lesions varied in size from a sixpence to a florin, and were round or oval in shape. The skin over them was unaltered at first, but as the swelling increased it became somewhat raised, and assumed a pinkish or purplish tinge, with small telangiectases ramifying over it. The

lesions were not definitely painful or tender on pressure. They tended to disappear spontaneously in a few months, leaving a depression from a distinct loss of subcutaneous tissue, but no scar, the skin over the depression being unaltered in texture, and the lanugo hair persisting. The first of those lesions appeared on the left side of the forehead seven years ago. It was soon followed by another on the left cheek below the malar bone. These underwent spontaneous involution. Since then other lesions of a similar type have appeared on the right side of the face, and the patient has never been quite free from them, at the time of exhibition one about the size of a florin being present below the right malar prominence. The exhibitor has had the case under observation for the last three years, and has found that their disappearance is accelerated by Finsen light treatment.

The nature of the case is uncertain. At first it was thought that it might be an anomalous case of Lupus erythematosus, as when first seen the most prominent feature was the erythematous and telangiectatic condition of the skin, and the affection corresponded in every detail to what Besnier had described as a peculiar form of Lupus erythematosus associated with deep swellings. Further observation of the case, however, led to the conclusion that the lesion was essentially hypodermal, and that the changes in the skin were secondarily produced probably to some extent mechanically by pressure, the exhibitor having recently observed a precisely similar condition of the skin resulting from the presence of a flat mass of paraffin situated in the hypoderm, which had been injected into a lady's cheek for the removal of wrinkles. Unfortunately the exhibitor had not been able to obtain a biopsy in the case so as to decide the more likely hypothesis that it might be a tuberculous condition, and of the nature of diffuse scrofulous gummata, which became absorbed without breaking down. A case of a somewhat similar type was recently described by Wende in the *Journal of Cutaneous Diseases* (January, 1911), under the heading of "Nodular Tuberculosis of the Hypoderm."

Sir MALCOLM MORRIS remarked that there were some cases in which the condition on the legs looked like Erythema induratum. There was left a cup-like depression without any ulceration. He had seen some cases much disfigured by attempts at treatment by injecting paraffin.

Dr. DORE said he had seen a case of Lupus erythematosus which became sclerodermic. Dr. Wilfrid Ward described some cases of sclerodermic lupus, but in these there were neither nodules nor depressions.

Dr. GRAHAM LITTLE was reminded of a somewhat similar case shown by him to the Dermatological Society of London in February, 1901. The patient, a young woman, had had disc-like granulomatous patches on the arm diagnosed as tuberculous, which had involuted rapidly and spontaneously, leaving atrophy; subsequently this patient had developed typical Lupus vulgaris of the face.

Dr. SEQUEIRA remarked that Wende's case recently described appeared to be of similar character. It went on for a long time and gave a positive reaction to tuberculin. The tumours were described as being like Erythema induratum, and they eventually disappeared.

Dr. SEQUEIRA showed a case of *acute Lupus erythematosus*. The patient, a deaf-mute girl, aged 17 years, had enjoyed good health until a year ago, when a red patch appeared suddenly upon the left cheek. This was followed a few days later by a similar patch upon the right cheek. The eruption had gradually spread since.

The eruption had the characteristic butterfly distribution, involving nearly the whole of both cheeks, and a narrow band across the root of the nose. The auricles were also symmetrically affected. The patches were of a rather dusky red tint, the colour disappearing entirely upon pressure, and there was very little scaling except upon the auricles. Upon the dorsum of each hand and on the extensor surface of each wrist there were numerous livid red spots, the size of a shilling, resembling in every point a toxic erythema commonly met with in this situation. The feet and legs were free. There were, so far as could be made out from the patient by signs, no subjective symptoms. The buccal mucous surfaces were quite free from eruption. There was no evidence of tuberculosis in the patient, and nothing pointing to intestinal toxæmia. The urine, examined since, contained albumen —about 1 in 12 on boiling. There were no casts.

The only point in the family history, which was obtained from a friend, was that the girl's mother had died from tuberculosis of the lungs.

Dr. Sequeira commented upon the fact that of about fifteen cases of this type of Lupus erythematosus that he had seen all the patients had been girls or young women. He thought that this fact had not received sufficient attention in the discussions of the ætiology of this variety of the affection. That it was toxic could not be doubted from the close resemblance of the lesions in many cases with those of

Erythema multiforme, a resemblance which had been insisted upon several times by Drs. Galloway and MacLeod.

Dr. Graham Little recalled two cases of acute Lupus erythematosus which he had exhibited, and which would be in the recollection of many members. The first case (*Brit. Journ. Derm.*, 1904, p. 470) was in a woman, aged 26 years, who had the eruption of Lupus erythematosus on the face, hands, arms, knees, and feet, and subsequently died of phthisis not long after the skin-eruption showed itself. The second case, also in a woman, was shown to the Section a few weeks ago. This patient had got nearly completely well since then on large doses of quinine and local application of calamine lotion.

Dr. Whitfield, referring to the question of the affection of males, said he had seen one case very much like the present one in the person of a lifeguardsman. He had a very small indeterminate patch which he diagnosed as Lupus erythematosus. This remained stationary for six months, and then the patient had an attack of typhoid fever, whereupon an acute outbreak supervened exactly like that in the present patient. Its disappearance was very slow after he got up from the typhoid.

Dr. Pernet remarked that toxic symmetrical conditions might leave permanent telangiectatic areas in the case described by him in the *British Medical Journal* of December 17th, 1910 (with diagrams).

Dr. MacLeod said he recorded a case very much like Dr. Sequeira's in which the Lupus erythematosus appeared suddenly on the face, and became scaly three or four months later. At first the diagnosis from Erythema multiforme was doubtful, but later it became definite, as the ears became affected and typical patches developed in the hands. Finally the patient died from Bright's disease within eight months from the appearance of the skin-trouble.

Dr. F. Parkes Weber showed a case of *Lichen scrofulosorum imitating psoriasis*. The patient, a boy, aged 5 years, had a fistulous tuberculous gumma removed, on March 16th, from the right upper extremity. About the commencement of April, whilst he was still under observation, the present eruption developed. The eruption was almost confined to the trunk, and consisted of minute pale, reddish-brown, scaly papules, which on the trunk were arranged in groups so as to simulate (April 13th) patches of psoriasis. Some of the papules on the buttocks were of a deeper red colour, and shiny, and there were a few on the face which resembled acne. There had been no itching. Dr. Weber has to thank his surgical colleague, Dr. Michels, for allowing him to show the case.

Dr. Whitfield showed (1) two cultures of *Trichophyton roseum* obtained from a case of *Tinea circinata of the arm*, with a photograph of the case. The peculiarity of the clinical lesion was the completely

bullous character of the edge of the ring. Dr. Whitfield said that T. roseum had been cultivated by Dr. Adamson and himself from beard ringworm, and by Dr. Cranston Low from ringworm of the nails. He was not aware that it had previously been found in tinea circinata in Great Britain.

(2) Two cultures of a somewhat ochreous nature, very flat lying, and only slightly powdery *Trichophyton ectothrix from Tinea tonsurans.* Clinically there was a large patch of reddened, but not swollen, skin on the scalp, with rather heavy silvery scaling, and many stumps. The microscope showed complete permeation of the hair, with very large oval elements and chains of similar mycelium wandering through the sheaths. The culture was shown for identification. The President said he could recognise it as an ectothrix, but was not familiar with the variety.

(3) A specimen of horny layer from the toes, showing *trichophytic invasion.* The scales had been kindly handed to him by Sir Malcolm Morris, who knew of Dr. Whitfield's interest in the condition. The patient had acquired an inguinal ringworm some nine years ago, and some little time later had suffered from "eczema" of the toes, which had gone on up to the present time.

Dr. Whitfield said that he was convinced that this was an important condition which was frequently overlooked. He had drawn attention to a short series of cases in 1908, and again in 1911, and Sabouraud had published an excellent paper on it in 1910. Cultivation, which was extremely difficult, had yielded in Sabouraud's hands the Epidermophyton inguinale. Dr. Whitfield had two cultures growing, but they were too young to identify at present. He would point out that, as he had stated in both of his papers, the infection might determine an acute vesico-bullous dermatitis indistinguishable from acute eczema or cheiropompholyx, or it might produce a chronic scaly condition, generally diagnosed as "gouty" eczema.

Dr. G. Pernet said that the late Dr. Radcliffe-Crocker and he had investigated a good many cases of so-called eczema of the toes and other parts from the point of view of fungus. Dr. Pernet had frequently found fungus. These cases had not been published, and, unfortunately, Dr. Pernet's descriptive notes of the fungi found had been mislaid by the late Dr. Radcliffe-Crocker. Dr. Pernet also referred to Djélaleddin-Mouktar's paper bearing on the subject in the *Annales de Dermatologie*, vol. iii, 1892, p. 885 ("De la Trichophytie des régions palmaire et plantaire").

Dr. Winkelried Williams showed (1) a girl, aged 17 years, suffering from *angio-keratoma,* limited to the little finger of one hand. The lesions were clustered telangiectasic points ; some had a little granulomatous cellular infiltration round them, and two had distinct corn-like thickening of the horny layer over them. One oblong papule near edge of nail showed under the diascope distinct lupus-like tissue.

(2) A boy, aged 8 years, with patch of three years' duration on cheek. The onset was a vesico-pustule closely resembling a vaccinia vesicle—in fact the doctor who saw it at the time thought it was an accidental vaccination. After this healed, leaving a scar, an eruption gradually developed round and especially above the scar. This appeared to be worse at one time than another. There were now clusters of small, rather larger than pin-head-sized areas in the corium. They were very slightly raised above the skin surface, and were of a yellow-ochre tint. The diascope showed a certain resemblance to lupus but more opaque and yellowish in tint. They have not reacted to a 5 per cent. tuberculin ointment, etc. The application of a 0·5 per cent. watery solution of eosin and exposure to direct sunlight rapidly afforded complete relief to this painful catarrh, and (in conjunction with X-ray treatment) has considerably reduced the lupus infiltration. Since the mercurial treatment it has been possible to have a Wassermann reaction taken : it was negative, while the tuberculin skin-reaction is strongly positive.

Dr. Whitfield doubted whether the case was one of lupus, considering it rather as sebaceous hypertrophy. There was much vascular dilatation.

Dr. Graham Little thought this was probably a mild case of Adenoma sebaceum ("Pringle" type of French authors).

(3) A very extensive case of *lupus* in an elderly woman, involving half the scalp and nearly the entire face. The greater part had undergone spontaneous involution, leaving a thin, white scar more resembling that left by Lupus erythematosus or a syphilide than a tubercular lupus. In consequence of this smooth scar, the possibility of a mixed tubercular and syphilitic lesion was considered, and a three months' course of mercury and iodide was administered with slight improvement. For a long time the greater part of the facial lesion remained obstinately catarrhal, and consequently very painful, and it resisted such remedies as boric applications, Brooke's ointment (ichthyol, salicylic and oleate of mercury).

CURRENT LITERATURE.

GRANULOMA PYOGENICUM. Udo J. Wile. (*Journ. of Cut. Dis.*, December, 1910.)

Under this term, suggested by Hartzell, the author reviews the subject of human so-called botryomycosis, and records the result of a study of two cases under his observation.

In Case 1 the lesion was a rapidly forming frambœsioid growth following a trivial injury to the cheek of a child, and attaining a mushroom-shape with a definite pedicle. Microscopically the growth was covered by epidermis, and composed of connective-tissue cells and a large number of newly formed blood-vessels and spaces with moderate inflammatory reaction near the base, where numerous micrococci were found.

In Case 2 there hung from the navel of a child, aged 2 months, a round, frambœsioid, soft, moist, easily bleeding tumour, apparently attached by a short thick pedicle. This was snipped off, and found microscopically that the surface was mostly ulcerated, and the tumour surrounded by a mass of exuded blood-fibrin and leucocytes. The body of the tumour was composed of granulation-tissue, with a fair number of small capillaries not presenting the striking feature of Case 1. A large number of polynuclear leucocytes extended from the periphery into the body of the tumour, and in all parts a moderate infiltration of small round cells and leucocytes existed. The bulk of the tumour was formed by cells of the embryonal connective-tissue type and endothelial cells, the latter taking part in the formation of new capillaries. The entire circumference was studded with clumps of, and single, micrococci. The structure of the pedicle corresponded with that of the body of the growth.

The author concludes from his own and others' findings that the growth is one primarily of young connective tissue, and in all the formation of blood-vessels is more or less notable. Leucocytic infiltration of the mononuclear and polynuclear variety is more or less present, the latter depending, at any rate to a degree, on superficial ulceration and infection. He concludes it is a variant of Granuloma simplex. It is not caused by a special fungus, but probably by the *Staphylococcus aureus*.

We may remind our readers that in 1908 Letulle put forward the theory of causation by an amœba, and this idea was supported by Labbé in 1909.

T. C. F.

CANCER IN TAR WORKERS. Jay Frank Schamberg. (*Journ. of Cut. Dis.*, December, 1910.)

A case of eruption and cancer due to tar came under the author's observation, and led to the inspection of other workers in a factory where tar paper was made by the men drawing the wet tar paper through rollers. In the process the hands and arms become thoroughly smeared with coal-tar, which was removed by the use of "heavy oil." Four workmen displayed evidence of carcinoma. The tar causes a keratosis of the hair-follicles with the formation of plugs with a black head. There may also be formed flattened keratosic discs, and from time to time pustular inflammation ensues. The hands and arms are specially evolved,

but a region like the scrotum may be implicated. Schamberg concluded that the carcinomatous changes are prone to occur as the workers come near the fifth decade of life. The histology of an epithelial growth is described. The author then reviews the subject of chimney-sweep cancer from soot, and then tar and paraffin cancer. He notes the tendency for the growths to undergo spontaneous involution, or to be destroyed by ulceration. The paper concludes with a discussion on the possibility of a radio-activity in coal-tar exciting the growths.

T. C. F.

THE NATURE OF EYELID XANTHOMA. S. Pollitzer. (*Journ. of Cut. Dis.*, December, 1910, and *Unna's Festschrift.*)

Pollitzer returns to the subject on which he has previously written, and contends that both on clinical and histological grounds there is good reason to separate the localised Xanthoma planum of the eyelids from the rarer widespread forms of xanthoma. His conclusions are founded on material derived from twenty specimens of Xanthoma palpebrarum, giving hundreds of sections. He says the so-called xanthoma of the eyelids appears as a yellow discoloration, which may gradually encircle the parts in contrast with the disseminated papules and nodules of true xanthoma though associated with these patches, and striæ may occur, for instance, on the palms. The xanthoma of the eyelids tends to appear in middle life, and persists.

Histologically, he says, the two diseases are distinguishable at a glance. The only point of resemblance is the presence of a large amount of fatty substance within, or apparently within, cells. He says all recent writers are agreed that Xanthoma tuberosum is a neoplasm made up of connective tissue or endothelial cells, which more or less rapidly undergo fatty degeneration, and the neoplasm is due to heterotopic fat-cells (Török) or to a hyperplastic connective-tissue cell growth (Pollitzer). A section of a well-developed Xanthoma palpebrarum shows all the elements of the skin in appearance normal, but the greater part of the cutis is literally filled with the peculiar cell-like masses and bodies known as "xanthoma-cells," which are fragmented and degenerated remains of muscle-fibres with proliferated sarcolemma or nuclei. The appearance is not due to "xanthoma cells" invading the muscular bundle, for the xanthoma cell is not an invading cell. Unlike the fat in sebaceous cells, it never runs together to make a large drop. The fat of Xanthoma palpebrarum is distinguishable from that of fatty infiltration or degeneration. In older specimens so-called "giant-cells of xanthoma" are found, but there is often no sign of cell-structure, and they consist of a homogeneous granulo-fatty mass, perhaps with some nuclei. Adjacent "cells" often show a thread-like fragment of tissue, which partly separates them. Again, the "cells" lie frequently in groups of the size of a muscle fasciculus, and separated by a connective-tissue stroma like a sarcolemma of a muscle-bundle. From this Pollitzer is struck with the small amount of muscle-tissue in the sections compared with the large amount in the normal eyelid. He notes changes in muscle-fibres suggesting a degeneration.

Pollitzer concludes that so-called Xanthoma planum palpebrarum is in no way related to Xanthoma tuberosum. It is the product of a peculiar degeneration of muscle-fibres of the eyelid. The paper is illustrated.

T. C. F.

SYPHILITIC POLYNEURITIS. Bonnet and Laurent. (*Ann. de Derm. et de Syph.*, August-September, 1910, p. 433.)

Multiple neuritis of syphilitic origin is sufficiently rare to deserve special record. These authors furnish a complete bibliography, showing the rarity of the event, and quote doubts of competent authorities as to its actual existence. They record a new case in which, in a malarial and chronic alcoholic patient, a chancre appearing in 1904 was followed in 1907 by tertiary ulcerative lesions and a temporary paralysis of the right arm and the right levator palpebræ; in 1909 by paralysis of all the limbs, all the symptoms being speedily cured by mercurial treatment. In some of the rare cases of the presence of polyneuritis in syphilitic persons this has been ascribed to mercurial intoxication, but mercurial polyneuritis is even more rare than syphilitic; the latter tends to occur in the earlier stages of syphilis and in association with other syphilitic manifestations, and is usually ameliorated by mercurial treatment.

E. G. L.

PROLIFERATING EPIDERMIC CYSTS. Dubreuilh and Tribondeau. (*Ann. de Derm. et de Syph.*, August-September, 1910, p. 417.)

This is an important histological contribution to the elucidation of the formation of certain types of epidermic cysts. It is established by these researches that proliferation may take place on the exterior surface, on the interior surface, and within the cyst itself; in this latter case complex tumours may result. Connective tissue invades the interior of the proliferated cysts thus formed through the keratinised epithelial cyst-wall. Serial sections show two kinds of cysts in the vicinity of the parent tumour: (1) secondary, quite independent and similar cysts; (2) cysts derived from proliferation of the epithelial cyst-wall of the parent cyst and still maintaining continuity with this Calcareous degeneration of the epithelial and connective-tissue elements may take place and a curious hitherto unnoted vacuolar degeneration of the epithelium.

The paper is well illustrated by nine figures.

E. G. L.

STUDY OF A CASE OF TRICHOSPORIA. Du Bois. (*Ann. de Derm. et de Syph.*, August-September, 1910, p. 447.)

Four varieties of parasites known as trichosporons are described as infecting the shaft of the hair, but never the follicle or the root, and never affecting the smooth skin. They do not cause the fall or loss of the hair, and are uncommon outside certain tropical countries, where they are generally grouped under the name of "Piedra." Du Bois describes a case occurring in a woman visiting his clinique in Geneva, in whom a new parasite constituting a fifth species was found, restricted to the hair of the genitals where these came in contact with the urine of the patient. The parasite was cultivated, and demonstrated to be of mycelial character with strong affinity for saccharine media; it was then discovered that the patient was diabetic. The clinical appearances of the affected hair had at first suggested the diagnosis of Trichorrhexis nodosa, which was only contradicted on microscopical examination.

Three plates illustrate the paper.

E. G. L.

IS IT POSSIBLE TO DEMONSTRATE THE DEATH OF LEPROSY BACILLI IN THE HUMAN ORGANISM? UNNA. (*Ann. de Derm. et de Syph.*, October, 1910, p. 482.)

UNNA combats the prevailing impression of hopelessness in face of a case of leprosy of which he accuses his countrymen since the date of the Berlin Congress. He claims that in the Victoria-safranin staining reaction we have a means of distinguishing dead from living leprous bacilli in the tissues, and records two cases in which frequently repeated biopsies demonstrated the absence of living bacilli in the tissue, the patient showing at the same time marked clinical improvement amounting to the cessation of cutaneous symptoms of the disease. The treatment consisted in local application of liquid carbonic acid, followed by ointments containing pyrogallic acid and sulphur; oil of gynocardia was given daily by the mouth and by injection.

E. G. L.

ON SOME POINTS IN THE PATHOLOGICAL ANATOMY OF LICHEN PLANUS OF WILSON. SABOURAUD. (*Ann. de Derm. et de Syph.*, October, 1910, p. 491.)

THE lesion of Lichen planus, says Sabouraud, is as specific as that of zona or of varicella. By a series of biopsies taken at various stages of development he shows that the papule is constituted by a proliferation of mononuclear cells in the papillæ which crowd out the interpapillary processes of the epidermis, and become œdematous to varying degrees, even in some cases to the degree of vesication. The œdema may be intra-cellular as well as intercellular (colloid degeneration). Groups of epidermic cells may be cut off from the epidermis by this infiltrate, and giant-cells of epidermic origin may be formed. The disease is, therefore, essentially one of the corium and not of the epidermis; but there are some characteristic changes in the latter also, of which hyperkeratosis and increase of the granular layer are the most important.

The paper is illustrated by twenty-five excellent figures.

E. G. L.

THE ELASTIC NETWORK OF THE WALL OF THE SUDORIPAROUS GLANDS. NICOLAS and FAVRE. (*Ann. de Derm. et de Syph.*, October, 1910, p. 487.)

THESE authors, by means of new methods of staining derived from Weigert's process, claim to have demonstrated in the wall of the sweat-gland the existence of an elastic network peculiar to it. These fibres may rest intact when the elastic fibres of the surrounding tissues are destroyed, a fact which would seem to point to a special constitution of these fibres.

E. G. L.

THE WASSERMANN REACTION IN ALOPECIA AREATA. DU BOIS. (*Ann. de Derm. et de Syph.*, November, 1910, p. 554.)

THIS paper follows one by Sabouraud, in which is stated the theory that syphilis is responsible for the majority of cases of extensive Alopecia areata. Du Bois investigated fourteen cases of Alopecia areata typical in every respect, and in eleven found a positive Wassermann reaction, when there were no symptoms

of syphilis, either hereditary or acquired. The three negative cases were the subjects of single alopecic patches which were speedily cured by local stimulation. The preamble of the paper concludes with the remark that the demonstration may one day be made that the graver forms of alopecia are the hereditary manifestations of an infectious state due to the treponema.

E. G. L.

ALOPECIA AREATA, NEW RESEARCHES ON THE CAUSATION OF. Sabouraud. (*Ann. de Derm. et de Syph.*, November, 1910, p. 545.)

Sabouraud is now of opinion that extensive alopecia is more commonly due to syphilis, either acquired or hereditary, than to any other single cause, and he claims that he had sufficient success with anti-syphilitic remedies in curing alopecia to warrant him in his belief. He selected cases of extensive alopecia for his observation on the ground that the more severe the disease the more likely was it to be characteristic.

E. G. L.

TREATMENT OF SYPHILIS BY THE NEW EHRLICH-HATA PREPARATION OF ARSENIC ("606"). Zaroubine. (*Ann. de Derm. et de Syph.*, December, 1910, p. 620.)

This is a judicious article on the much-discussed merits of this treatment. The author propounds four questions: (1) Is this remedy specific against syphilis? (2) Is it superior to all others yet known? (3) Is syphilis radically cured by this remedy? (4) Is the remedy without risk? The first two questions the author answers affirmatively. Too short a time has elapsed to answer the third question, but he is hopeful that it will be possible to answer this also affirmatively. In response to the fourth question he gives a careful *resumé* of the dangers and accidents to be feared. He considers the time not ripe for the routine treatment of all cases by this method to the exclusion of the old and tried remedies.

E. G. L.

PITYRIASIS RUBRA PILARIS AS A FAMILY DISEASE. De Beurmann, Bith and Heuyer. (*Ann. de Derm. et de Syph.*, December, 1910, p. 609.)

These authors record an exceptionally interesting series of four cases of this rare disease, occurring in four members of one family, brothers and sisters, two males and two females, of ages varying from twenty-eight to twelve, and of perfectly characteristic clinical aspect. All patients (except one with signs of apical phthisis) were constitutionally well. The father had for many years a scaly redness of the face and was subject to chronic bronchitis. The mother had had no skin-disease and had died of pleurisy and cardiac disease. Two other children showed no skin-affection, but two cousins were reported to have similar skin-eruptions to these here described. The family distribution in these cases is of unique occurrence and gives support to the theory of a tubercular causation, which was partly confirmed by the intra-dermic reaction in three cases and by a positive reaction with tuberculin in one case.

E. G. L.

REVIEW.

Progressive Medicine.*

The March volume does not contain much of dermatological interest, with the exception of a report of Nichols's experimental work on frambœsia.

Nichols has made a study of experimental yaws in rabbits and in monkeys, and has proved what was believed before, that the disease is not identical with syphilis, although the lesions in man bear many striking resemblances. The surest way to differentiate the organism is by the comparison of the lesion produced by syphilis and yaws in the monkey. In yaws the incubation is two to three weeks; the lesion is elevated, slightly scaly, and very œdematous. In syphilis the incubation is about four weeks; the lesion is flat, dry, and very scaly. The spirochæte of yaws has been called *Treponema pertenue*, and is slightly thicker than the spirochæte of syphilis, less rigid, and less regular in its twists. The complement fixation reaction may be observed in rabbits infected with the spirochæte of yaws, as well as those infected with the spirochæte of syphilis. Rabbits may be easily infected in the testicle, infection showing enlargement and the presence of nodules varying in size from a pea to that of an olive, with necrosis, infiltration of round-cells, and œdema. This lesion makes possible the investigation of problems concerning the cultivation, immunity, and treatment of yaws which have hitherto baffled investigators.

J. L. B.

THE ELEVENTH VOYAGE D'ETUDES MÉDICALES.

We have been asked to give notice that the Eleventh Voyage d'Etudes Médicales will take place from August 28th to September 11th, 1911, under the personal direction of Prof. Landouzy. It will include the stations in the South-East of France, visited in the following order: Vals, Montmirail, Lamalou, Alet, La Fou-Saint-Paul-de-Fenouillet, Prats-de-Mollo, La Preste, Amélie-les-Bains, Le Boulou, Banyuls-sur-Mer, Molitg, Le Vernet, Thuès, Mont-Louis, Font-Romeu, Les Escaldes, Ax-les-Thermes, Ussat, Aulus, Salies-du-Salat.

Reduced fares will be charged by the railway companies to the *rendez-vous* at Lyons. Foreign medical men will have the benefit of this reduction on the French lines. A similar reduction will be allowed from Toulouse, the end of the journey. The charges for the tour are 350 francs, inclusive of first class railway fare, carriages, luggage, and all hotel expenses.

Medical men desirous of joining the tour are requested to communicate with Dr. Carron de la Carrière, 2 Rue Lincoln, Paris, or to Dr. Jouaust, 4 Rue Frédéric-Bastiat, Paris.

* *Progressive Medicine*, vol. xiii, No. 1, March 1st, 1911. Philadelphia and New York: Lea and Febiger.

The support received by

Fellows' Syrup of Hypophosphites

from the Medical Profession of all Nations is
a unique and striking testimony
to its four decades of
usefulness

REJECT < Worthless Substitutes
Preparations "Just as good"

AN ANTISEPTIC TOILET AND NURSERY POWDER.

Prepared with Boric Acid.

Awarded Silver Medal International Health Exhibition, London, 1884.

The Practitioner says: "Entirely deserves the excellent reputation it has gained."
The British Medical Journal says: "An improvement on the old-fashioned Violet Powder."
The Nurses' Journal reports: "We have tried it extensively and found it most useful."
The Queen.—"Fragrant, Soothing, Cleanly."

Useful for Dusting on the Arm after Vaccination.

In Packets 6d. Boxes 1s.
Of all Chemists.

Examined and certified by the Imperial Institute of Hygiene, 1908.

JAMES WOOLLEY, SONS & Co., Ltd., MANCHESTER.

SCHINZNACH LES BAINS

SWITZERLAND (Railway Station, Schinznach-Bad).

STRONGEST HOT SULPHUR SPRINGS.

Baths in the Hotel. Pulverization. Douches.

Excellent arrangements and latest improvements for the treatment of

Gout and Gouty Diseases, Eczema, Acne disseminata and rosacea, Psoriasis, Urticaria, Furunculosis, Rheumatism, Sciatica, Lumbago.

Beautiful walks and drives. Excellent Trout Fishing. Tennis. Fine scenery. Lifts. Electric Light.

English Protestant and Roman Catholic Service.

Season: May to September.

FOR ENGLISH PROSPECTUS APPLY TO PROPRIETORS—
AMSLER, RILLIET & CO.

ENGLISH MADE.

MIDGLEY'S MEDICATED SOAPS

Are guaranteed absolutely pure, and do not contain any free alkali, sulphate of soda mineral colouring matter, chalk, resin, talc, or sugar.

The great advantages of using our medicated soaps in the treatment of skin diseases are their great cleanliness, and the ease with which applications are made. They are not greasy or messy like ointments.

COMBINATIONS.

Alkaline Base.

No. 1. Ichthyol and Sulphur.
No. 2. Sulphur and Marble Sand
No. 3. Marble Sand Soap
No. 4. Sulphur Soap
No. 5. White Birch Tar
No. 6. Boracic Acid
No. 7. Silicon
No. 23. Silicon and Sulphur
No. 25. Sulphur and Camphor
No. 33. Mercurial Sulphur

Superfatted Base.

No. 8. White Rose Soap
No. 9. Sulphur
No. 10. Ichthyol
No. 11. White Birch Tar and Sulphur
No. 12. Corrosive Sublimate
No. 13. Eucalyptol
No. 14. Creolin
No. 15. Ichthyol and Tar
No. 16. Menthol
No. 17. Menthol and Eucalyptus
No. 18. Naphthol and Sulphur
No. 19. Sulphur, Camphor, and Balsam of Peru
No. 20. Thymol
No. 21. White Precipitate
No. 24. Heliotrope
No. 28. Cold Cream and Oatmeal
No. 30. Naphthol
No. 31. Creolin and Sulphur
No. 40. Resorcin and Salicylic Acid

NEW COMBINATIONS.

Superfatted Base.

No. 29. Formaldehyde Soap
No. 39. Ichthyol and Salicylic Acid Soap
No. 45. Sulphur and Carbolic Acid Soap
No. 34. Nicotine Soap

No. 27. Biniodide of Mercury (Alkaline Base).

Special Note.—MIDGLEY'S MEDICATED SOAPS are reserved exclusively for the use of the medical profession, and are not advertised to the public in any way.

When ordering Medicated Soaps, specify "MIDGLEY."

CHAS. MIDGLEY, LIMITED,

WHOLESALE CHEMISTS,

17, ST. ANN'S SQUARE, MANCHESTER

WHOLESALE AGENTS—

LONDON—Edwards & Sons, Barclay & Sons, Butler & Crispe, Sanger & Sons, Newbery & Sons.

LIVERPOOL—Evans, Sons, Lescher & Webb, Ltd., John Thompson, Ltd.

EDINBURGH—Raimes Clark & Co. NEWCASTLE-ON-TYNE—Ismay & Sons.

Entered at the New York Post Office as Second Class Matter.